FBMC
proven benefit solutions

P.O. Box 1878, Tallahassee FL 32302-1878 • Customer Service 1-800-342-8017

State of Washington HCA
State Employee's Short Plan Year
WASHINGTON FLEX ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Medical Expense Flexible Spending Account.
July 1, 2006, through December 31, 2006

Name (Please Print) Last	First	MI	Social Security #

Home Address Street	City	State	ZIP

Agency Name	Daytime Phone ( )	Home Phone ( )	Date of Hire	Date of Birth

Enrollment Status: ☐ Open Enrollment ☐ Change in Status ☐ New Hire	Payroll Effective Date	Plan Effective Date

☐ **Full-time permanent**	OR	☐ **Seasonal/Part-time Employee** (See payroll deduction information below)*
6 months paid; 12 paychecks		I expect to receive _____ **PEBB paychecks** between July 1, 2006, and December 31, 2006.

Indicate the amount you wish to pay through tax-free salary deduction by completing the section below.
Complete the worksheet provided in your Enrollment and Reference Guide before deciding on the amount.
If you have questions, consult your Enrollment and Reference Guide or call FBMC Customer Service at 1-800-342-8017.

In Box #1, indicate the dollar amount you elect to contribute for the **short plan year**, which is July 1, 2006, through December 31, 2006.
In Box #2, indicate the number of PEBB paychecks you expect to receive during the **short plan year**.
In Box #3, indicate the deduction amount per paycheck by dividing Box #1 by Box #2 (Note: if Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

For uninsured eligible medical expenses incurred by you, your family members or both.
[Maximum allowable contribution is $2,400; minimum is $240.]

Box #1
Short Plan Year Annual Amount _____

Box #2
Divide by the number of PEBB paychecks you will receive during the short plan year. Enter **12** for full-time, permanent employees, 12 or **less** for new hires or Seasonal/PartTime employees. _____

Box #3
Deduction Per Regular Paycheck _____

*You must take an equal FSA deduction for each pay period during the 2006 Short Plan Year. If you are a full-time employee, divide the amount you want to contribute during 2006 by 12 to calculate the FSA deduction for each pay period; if you work less than 12 months of the year, divide the amount of your 2006 Plan Year contribution by the number of paychecks you will receive during the Short Plan Year (July 1, 2006, to December 31, 2006).

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in my FSA not used during this plan year and grace period will be forfeited since it cannot be carried forward to the next plan year.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand that the funds in my FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change In Status with the contract administrator within 30 days of the event or before the end of the plan year.
- I understand and agree that my employer and FBMC, the contract administrator, will not incur, and I specifically release from them, any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Please send this signed form to the attention of FBMC Enrollment Processing, P.O. Box 1878 Tallahassee, FL 32302-1878 or fax to 850-514-5806.

By signing this form you certify that you expect to receive the number of PEBB paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, planned retirement or any other anticipated leave.

Employee Signature	Date Signed

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

FBMC/WASSPY/0306